City of Newton

HEALTH AND HUMAN SERVICES DEPARTMENT
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Public Health
Prevent. Promote. Protect.

MEDICATION PERMISSION FORM & POLICY

This form must be completed by a **health care provider** and **parent** before any medication (over-the-counter or prescription) can be administered at school. (M.G.L. Chapter 112 § 80)

Student name _____ School _____Grade: ___ D.O.B.: _____ M/F

HEALTH CARE PROVIDER: Please complete a separate form for each medication to be administered at school.

Medication _____ Dosage _____ Route _____

Frequency _____ Time(s) to be given at school_____

Possible side effects: _____

Special Instructions: _____

Date of order: _____ Discontinuation date: _____

Diagnosis _____ Drug/Food Allergies: _____

Name of licensed prescriber: _____ Title _____
print

Signature of licensed prescriber: _____Date: _____

Address: _____ Phone:_____

Consent for self administration: The student has been instructed to self administer medication and may do so at school. Yes____ No____ (The school nurse must determine it to be safe and appropriate.)

PARENT/GUARDIAN:

Print Name: _____ Relationship to student _____

Please list all other medications. _____

I, the undersigned parent or guardian, give permission to the school nurse (or school personnel designated by the school nurse) to administer the above medication to my child or to supervise my child in taking the above medication if approved to do so by the school nurse. I authorize the school nurse to share information about such medication administration as the school nurse deems necessary for the health and safety of my child. I agree to release, indemnify and hold harmless the City of Newton, the Newton School Committee and their employees and agents from and against any claim either I or my child may have as a result of any act or omission which may arise out of this authorization.

Signature of Parent / Guardian _____ Date _____

Phone numbers: Home _____ Work _____Cell _____

Field Trip Plan: _____

Signature of School Nurse: _____

School Medication Administration Policy: see next page

SCHOOL MEDICATION ADMINISTRATION POLICY

The school nurse is responsible for the administration of all medication. For school-day sponsored field trips and for certain medications, the school nurse can delegate medication administration to trained personnel under the supervision of the nurse.

The medication permission form (see other side) must be completed in ink and be on file in the Health Office before any medication is administered.

The following statements highlight the main points of the policy. The entire policy is available in each health room, at the Health and Human Services Department and on the web site www.newtonma.gov

- Medication administration should be scheduled at times other than during school hours, whenever possible.
- All medication must be delivered by the parent/guardian or designated adult.
- Only a 30-day supply of medication will be accepted at any time.
- All medication must be delivered in a pharmacy or manufacturer labeled container.
- The pharmacy-labeled container can be used in lieu of a health care provider's order only for short-term medications, i.e. those medications to be given for 10 school days or less.
- Self medication can be allowed under certain circumstances after consultation with the school nurse.
- The school nurse must be notified **in advance** if medication is scheduled to be administered during a field trip.
- **This Medication Permission Form must be renewed at the beginning of each school year.**

Over-the-counter medication will be treated the same as prescription medication.

This means that medications such as Tylenol, Benadryl, Advil, etc., require a written order from a health care provider and a supply of the medication provided by the parent.

For office use only

Medication Quantity Received by School:

Amnt: __________	Date: __________	Exp. Date: __________	Amnt: __________	Date: __________	Exp. Date: __________
Amnt: __________	Date: __________	Exp. Date: __________	Amnt: __________	Date: __________	Exp. Date: __________
Amnt: __________	Date: __________	Exp. Date: __________	Amnt: __________	Date: __________	Exp. Date: __________
Amnt: __________	Date: __________	Exp. Date: __________	Amnt: __________	Date: __________	Exp. Date: __________
Amnt: __________	Date: __________	Exp. Date: __________	Amnt: __________	Date: __________	Exp. Date: __________
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Amnt: __________	Date: __________	Exp. Date: __________	Amnt: __________	Date: __________	Exp. Date: __________
Amnt: __________	Date: __________	Exp. Date: __________	Amnt: __________	Date: __________	Exp. Date: __________